

THE DIVISION OF HEALTH OF THE STATE OF ILLINOIS  
STANDARD CERTIFICATE OF DEATH

FILED OCT 29 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

STATE FILE NO. 9789

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Clair Louis				c. CITY OR TOWN E. St. Louis			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmary				Length of stay in lb few hours			
3. NAME OF DECEASED (Type or print) First Saphronia Middle Hendricks Last				4. DATE OF DEATH Month 10 Day 16 Year 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-1864	
9. AGE (In years last birthday) 93		IF UNDER 1 YEAR Months 6 Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		100. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (City and state or country) Mobile, Alabama				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Tom Weaver				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mammie Jackson Address 1338a Bond Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of The Left Lung Due to (b) Sepsis of The Colon Due to (c) Direct Union of The Jejunum Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 48 hours
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year		572.1			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 6/17/56, to 10/16/57 and last saw her alive on 10/16/57. Death occurred at 2:37 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Chas. H. F. (Signature)				22b. ADDRESS 1414 K. Ave.		22c. DATE SIGNED 10/18/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-20-57		23c. NAME OF CEMETERY OR CREMATORY Booker Washington		23d. LOCATION (City, town, or county) East St. Louis, Illinois	
24. FUNERAL DIRECTOR C.T. NASH FUNERAL HOME ADDRESS 111 N. 13th St. E. St. Louis, Mo.				25. DATE RECD. BY LOCAL REG. OCT 19 57		26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. S.P.	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed

*M. Frances*

Licensed Embalmer No. ....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.